DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Federally Qualified Health Centers
Managed Care Plans
CSO Administrators
Physicians
Regional Administrators

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Medical Assistance Administration (MAA)

Subject: Discontinued State-Unique Procedure Codes Used for FQHCs

Effective for dates of service on and after October 1, 2003, the Medical Assistance Administration (MAA) will **discontinue** all state-unique procedure codes previously used in the Federally-Qualified Health Center (FQHC) Program.

Coding Changes

The Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay electronic claims using a standardized set of procedure codes. In order to comply with HIPAA requirements, MAA is **discontinuing all state-unique procedure codes** and will require the use of applicable CPT™ and HCPCS procedure codes.

Discontinued State-Unique Codes for Fee-For-Service Encounters

The following state-unique codes for FQHC fee-for-service encounters will be discontinued for claims with dates of service after September 30, 2003:

Discontinued State-Unique Code	Description
9000M	Medical Services Encounter
9001M	Medical/Maternity Encounter
5900M	Maternity Encounter
9006M	Maternity Support Services (MSS) Encounter
9007M	Maternity Case Management (MCM) Encounter
0200D	Dental Service Encounter
9701M	Mental Health Encounter
9005M	Chemical Dependency Treatment Programs

Billing for Encounters using CPT and HCPCS Codes

All services* must be billed using the CPT or HCPCS code that describes the actual service performed, with one of the following encounter codes and modifiers (if applicable) on another line of the claim form.

Bill one date of service per line for all services except global maternity or dental procedures.

Discontinued Code	Replacement Procedure Code/ Modifier	Description	Limits
9000M	T1015	Clinic visit / encounter, all-inclusive	Limited to **one** encounter per day.
9001M or 5900M	T1015 - TH	Clinic visit / encounter, all-inclusive with Obstetrical Services modifier	Limited to **one** encounter per day. Attach **modifier TH to encounter code T1015** when billing with a global maternity code. This will allow the provider to bill multiple units of T1015 to represent each time the client was seen for the billed global procedure code.
9006M	T1015	Clinic visit / encounter, all-inclusive	Limited to **one** encounter per day.
9007M	The MSS and MCM programs have been redesigned. Your MCM number will be discontinued. Use your MSS number to bill for encounters under the new "Integrated MSS / Infant Case Management Program."		
0200D	T1015	Clinic visit / encounter, all-inclusive	Limited to **one** encounter per day. Multiple units are allowed only when billing with a global dental code.
9701M	T1015 - HE	Clinic visit / encounter, all-inclusive with Mental Health Program modifier	Limited to **one** encounter per day. T1015-HE is limited to **only** those FQHCs who are contracted with a Regional Support Network (RSN). A corresponding fee-for-service code is not required.
9005M	T1015	Clinic visit / encounter, all-inclusive.	Limited to **one** encounter per day.

*Mental health encounters billed by RSN-contracted FQHC's don't need a corresponding fee-for-service code.

Changes to the Monthly Reconciliation Report

Since HCPCS code T1015 will now be used to describe encounters for a variety of different types of services, the FQHC's encounter rates will be tied to the specific billing provider type. The totals on the Monthly Reconciliation Report will represent all services billed by that particular provider number (e.g. the dental provider number, the physician provider number, or the MSS provider number). Each of these individual totals will be added together to determine the amount of the gross adjustment. Totals will no longer be calculated by the main FQHC provider number.

Billing for Delivery Case Rate Enhancements

When an eligible pregnant woman who is assigned to an MAA managed care plan delivers, MAA makes a supplemental Delivery Case Rate (DCR) enhancement payment directly to the FQHC. **The FQHC (or the managed care plan on behalf of the FQHC) may bill MAA for the DCR enhancement only when the FQHC's provider or contracted provider actually does the delivery**. Do not bill MAA for the DCR enhancement if another provider performs the delivery. However, MAA will pay the FQHC the DCR enhancement if the FQHC bears full financial risk for deliveries done by other providers through its contract arrangements with the managed care plan.

Bill MAA for the DCR enhancement using the **delivery only code 59409 or 59514 with modifier UC**. Modifier UC is a payer-defined modifier. MAA defines UC as "FQHC/RHC Service." Use the ICD-9-CM diagnosis code V68.9 (unspecified administrative purposes).

Billing for BH+ Clients Maternity Supplements

When an eligible pregnant woman who is enrolled in Basic Health Plus (BH+), and is on the "S" pregnancy program, delivers, MAA makes a supplemental enhancement payment (referred to as an "S-Kicker" enhancement) directly to the FQHC. **The FQHC (or the managed care plan on behalf of the FQHC) may bill MAA for the S-Kicker enhancement only when the provider or contracted provider actually does the delivery**. Do not bill MAA for the S-Kicker enhancement if another provider performs the delivery. However, MAA will pay the FQHC the S-Kicker enhancement if the FQHC bears full financial risk for deliveries done by other providers through its contract arrangements with the Healthy Options plan.

Bill MAA for the S-Kicker enhancement using **unlisted maternity care and delivery code 59899 with modifier UC**. Modifier UC is a payer-defined modifier. MAA defines UC as "FQHC/RHC Service." Use the ICD-9-CM diagnosis code V68.9 (unspecified administrative purposes).

To obtain this document electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).